
Mental Health Care in the Primary Care Setting:

Challenges, Successes and Opportunities for Improvement

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INTRODUCTION

Rationale

Primary care providers play vital roles, both directly and indirectly, in mental health care. Over 80 per cent of Canadians visit their family physician (FP) each year.¹ Research in Ontario found that over 50 per cent of people with psychological disorders who receive mental health care receive it from their FP.² Others have reported high rates of mental health problems in primary care as well.³⁻⁵ It is estimated that almost half of the mental health problems presenting in FPs' offices go undetected.^{6,7} Family physicians report poor availability of psychiatry referral. When FPs in Saskatchewan were surveyed about access to various health care services in their community, such as psychiatrists, obstetricians/gynecologists, long-term care beds, and diagnostic services, 60 per cent of respondents felt that access to psychiatrists was fair or poor;⁸ only long-term care beds were perceived to be more difficult to access. Mental health problems in general place a heavy burden on well-being, the health system, and population health.^{9,10} Together, these statistics underscore the importance of primary care in the detection, treatment, and management of mental health problems.

One approach to primary mental health care (mental health care provided in the primary care setting) that is growing in popularity is shared mental health care. **Shared mental health care (SMHC)** is mental health care delivered through a collaborative arrangement between family physicians and mental health professionals—such as psychiatrists, psychologists, or counsellors—in the primary care practice setting. A position paper developed jointly by the College of Family Physicians of Canada and the Canadian Psychiatric Association in 1996 recommended a shared care approach to treating mental health problems in the primary care setting.¹¹ Although the literature defines several types of shared mental health care,^{12,13} we classify shared care into three main models: replacement, consultation-liaison, and education-liaison.

- **Replacement model:** the mental health professional (MHP) and FP are co-located in the same clinic, but there is no explicit interaction needed between the MHP and FP. The FP refers patients with mental health problems to the MHP, and the MHP assumes primary responsibility for the mental health treatment of the patient. Increased interaction between FPs and MHPs or improvement in FPs' education or expertise in mental health issues is not expected or intended, but may occur as a side effect of the shared care arrangement.
- **Consultation-liaison (C-L) model:** a collaborative arrangement between FPs and psychiatrists or other MHPs, in which the MHP supports the FP with mental health care of patients through education and expert advice (liaison) and some direct assistance with mental health care for individual patients (consultation).
- **Education-liaison model:** an MHP provides short training workshops or seminars to FPs, and ongoing liaison with FPs for a period following the training component. This liaison occurs either through regularly scheduled follow-up meetings or through the MHP being available to the FP on an as-needed basis.

Various literature reviews and meta-analyses have been conducted on shared care, but they have tended to be narrow in scope. For example, Katon and Gonzales¹⁴ conducted a literature

review on consultation-liaison psychiatry, in which psychiatrists provide both direct consultation with patients and collaborative liaison with primary care physicians, but they excluded other models of shared mental health care. Brown and Schulberg,¹⁵ Bower et al.¹⁶ and Hemmings¹⁷ reviewed psychological treatments delivered in primary care, but excluded pharmacologically-based treatments. To our knowledge, no one has conducted a systematic literature review that compares the effectiveness of various models, treatments, and other characteristics of SMHC. Such a review could bring providers, managers, policy makers, and researchers one step closer to answering the question: Is SMHC (or are specific models or characteristics of SMHC) best practice?

The extent of shared mental health care in Saskatchewan appears to be limited but growing. A 2001 survey conducted by the College of Family Physicians of Canada found that 11.6 per cent of family physician respondents in Saskatchewan practice in community clinics or community health centres. It is unknown what proportion of these clinics and centres include MHPs. Saskatchewan currently has five cooperative community clinics and over 20 integrated primary health care sites. Although these clinics and sites vary in their approach and team composition, several of them include linkages to mental health services.¹⁸

Research Questions

Begun by the former Health Services Utilization and Research Commission (HSURC) and completed by the Health Quality Council, this research project was conducted to answer the following research questions:

1. How do different models of SMHC compare to each other and to usual family physician care in terms of effectiveness?

To answer this question, we conducted a systematic literature review on the effectiveness of shared mental health care (see Phase 1, below).

2. How is mental health care currently being delivered in Saskatchewan's primary care setting?

We addressed this question through a mail survey of all family physicians in Saskatchewan (see Phase 2, below).

3. What are the challenges and solutions to achieving best practices in primary mental health care in general, and in Saskatchewan in particular?

For this question, we completed a literature review of challenges and solutions, and a one-day focused workshop with mental health professionals, managers, and consumer advocates (see Phase 3, below).

Stated simply, the purpose of this project was to look at best practices in primary mental health care, current practices in Saskatchewan, and how to bridge the gap between the two.

PHASE 1: EFFECTIVENESS OF SHARED MENTAL HEALTH CARE

Method

To determine the effectiveness of shared mental health care, we conducted a systematic literature review. A systematic literature review involves systematically searching published and unpublished literature sources according to specified search terms, systematically

assessing the relevance of each document according to specified criteria, and systematically appraising the quality of each research study. Our searches included Medline, PsycINFO, CINAHL, Cochrane Library, NHS Centre for Reviews and Dissemination, an annotated bibliography of shared mental health care,¹⁹ key contacts, and selected websites.

Each of the articles identified through our search strategy was assessed, from the abstract or full article as required, for relevance to our literature review. Articles that met all of the following relevance criteria were included in our review:

- Randomized controlled trials or non-randomized controlled trials that measured outcomes associated with “shared mental health care” versus “usual family physician care” (the care that an FP would normally provide) in the primary care setting. In other words, there had to be a treatment group and a comparison group
- Included pre- and post-intervention measurement of outcomes
- Measured *effectiveness*, which was defined to include symptomatology, level of functioning, occupational functioning, or mental health status. (Other measures of interest, though not necessary to be included in our review, were *patient satisfaction* and *cost-effectiveness*)
- Studied patients/clients with a mental health problem
- Published in English language
- Published between 1991 and 2002 inclusive

Articles were excluded if they met any of the following exclusion criteria:

- Most or all patients had a specific physical health problem, e.g., depression in people with diabetes
- Sample size per group was less than 30
- The intervention involved mental health care that was exclusively provided by the FP. (For a study to be included in our review, there had to be some involvement of an MHP, either directly (i.e., they provided treatment to the patients) or indirectly (e.g., they provided education or consultation to the family physician).)
- Most or all patients were seniors or children/adolescents¹

¹ We decided to exclude SMHC studies that focused specifically on seniors or youth because we felt that many of the mental health issues faced by these populations are qualitatively different from those of the adult population, and the literatures on seniors and youth were relatively small. However, we provide the following selected references for those who may be interested in reading more:

Seniors:

Arthur A, Jagger C, Lindesay J, Matthews R. Evaluating a mental health assessment for older people with depressive symptoms in general practice: A randomized controlled trial. *British Journal of General Practice* 2002; 52: 202-207.

Callahan CM, Hendrie HC, Dittus RS, Brater DC, Hui SL, Tierney WM. Improving treatment of late life depression in primary care: A randomized controlled trial. *Journal of the American Geriatrics Society* 1994; 42:839-846.

Relevance decisions were usually made by a single researcher. More difficult decisions were resolved through discussion between two of the project researchers.

Articles that met relevance criteria were then appraised for study quality. Two researchers appraised each relevant article according to an appraisal tool developed by the research team. Appraisal criteria fell under five categories (sample appraisal items given in parentheses):

1. **Selection bias:** systematic differences in comparison groups (e.g., Were groups similar at baseline regarding outcome measures?)
2. **Performance bias:** systematic differences in care provided apart from intervention being evaluated (e.g., Are expected differences in exposure (the extent to which the planned treatments were actually received) present?)
3. **Attrition bias:** systematic difference in withdrawals from the study (e.g., Were there differences between groups in withdrawal rate?)
4. **Detection bias:** bias in outcome assessment (e.g., Were outcome assessors aware of the assigned therapy?)
5. **Construct validity:** the extent to which the results support the theory behind the research (e.g., Have plausible alternate explanations for the findings been addressed?)

Each appraisal item was first assessed for adequate or inadequate *report quality* (whether there was sufficient information reported in the article to make an assessment); if report quality was adequate, the rater also assessed *study quality* for that item (based on the information provided, whether the study was of acceptable quality for that particular attribute). The two raters compared their appraisal ratings, and resolved disagreements through discussion. Once the appraisal ratings for each item were finalized, one of the researchers summed the number of "inadequate" report quality ratings and "unacceptable" study quality ratings in each of the five appraisal categories and overall to calculate the "overall study quality team rating," which were classified as strong, good, weak, or poor according to cutoff scores. Studies assigned poor quality ratings were excluded from our analysis.

After we calculated study quality ratings, one researcher tabulated and compared studies on various characteristics and results for each study, including: effectiveness (whether the shared care intervention produced significantly better outcomes than usual FP care), effectiveness by length of follow-up period, patient satisfaction (whether patients were significantly more satisfied with shared care than usual care), sample size per group, type of mental health

Unutzer J, Katon W, Callahan CM, Williams JW, Hunkeler E, Harpole L, Hopping M et al. Collaborative care management of late-life depression in the primary care setting. *Journal of the American Medical Association* 2002; 288 (22): 2836-2845.

Williams JW, Barrett J, Oxman T, Frank E, Katon W, Sullivan M et al. Treatment of dysthymia and minor depression in primary care: A randomized controlled trial in older adults. *Journal of the American Medical Association* 2000; 284:1519-1526.

Children and adolescents:

Bower P, Garralda E, Kramer T, Harrington R, Sibbald B. The treatment of child and adolescent mental health problems in primary care: A systematic review. *Family Practice* 2001;18(4): 373-382.

problem studied, type of MHP involved in the intervention, whether patient education was a component of the program, and patient selection method.

Although not originally planned, we also reviewed the cost-effectiveness of shared mental health care due to demand from our stakeholders. We based our assessment of the cost-effectiveness of shared mental health care on the subset of effectiveness studies that included a cost component. For each of these studies, we applied universally accepted criteria for assessing economic evaluations.²⁰

Findings

Forty studies were included in our review.²¹⁻⁷⁵ In fact, there were only 35 separate studies. However, some of the replacement studies included more than one intervention group, yielding a total of 40 relevant shared care "groups." For example, one study included three shared care groups: one group of patients received antidepressant medication and counselling from a psychiatrist, another received cognitive behavioural therapy from a clinical psychologist, and the third group received general counselling from a social worker. Because all three groups in this example were independent shared care interventions, we counted them as separate studies. The majority of the studies were classified as either replacement model (21 studies) or consultation-liaison model (11 studies). The remaining three studies were characterized as education-liaison studies.

Our analysis did not include a calculation of effect sizes; thus, when we present effectiveness findings, we are referring to the number or percentage of studies that found SMHC was significantly more effective than usual care, not the magnitude of those differences in effectiveness. We partially address this limitation, however, by examining *clinically relevant effectiveness*; that is, we identified those studies that assessed clinical outcomes based on clinically acceptable benchmarks, such as the number of patients who were above (or below) an established clinical cutoff score at follow-up, or the number of patients who achieved 50 per cent or greater improvement in baseline clinical scores (see next section). Although we report both the numbers and percentages of studies that found SMHC to be more effective, interpret the percentages with caution as several of these are based on a small number of studies.

Is shared mental health care more effective than usual FP care?

SMHC was considered effective if the patient group receiving SMHC had significantly better outcomes or greater improvement in outcomes than the patient group receiving usual FP care. These outcomes could be measures of symptomatology, functioning, or mental health status. In general, patients in both shared care and usual care significantly improved between baseline and follow-up, but we were interested in determining whether shared care produced even better outcomes than usual care.

For overall improvement, we found that for 27 of 40 studies (68%), SMHC resulted in significantly improved symptoms or functioning relative to usual care. The proportion of SMHC interventions that were more effective than usual care was similar for each shared care

model: 18 of 26 replacement studies (69%), 7 of 11 C-L studies (64%), and 2 of 3 education-liaison studies (67%).

We also looked at clinically relevant effectiveness of shared care. Clinically relevant effectiveness refers to a level of improvement in symptoms or functioning that is accepted as clinically meaningful, such as the percentage meeting a threshold or cutoff score (often referred to as recovery) or the percentage who improved by a specified percentage, often 50 per cent (referred to as remission). When you look at only those studies that included clinically relevant measures of effectiveness, 19 of 24 studies (79%)—13 of 15 replacement studies, 6 of 8 C-L studies, and 0 of 1 education-liaison study—found that shared care was superior to usual care in terms of recovery or remission.

The proportion of effective SMHC interventions did not appear to vary by the length of follow-up period. Whether we looked at effectiveness by short term (less than 6 months), medium term (6 to 11 months), or long term (12 months or longer) follow-up, about two-thirds found shared care to be more effective than usual care. Keep in mind, however, that particularly for longer follow-up periods, a ceiling effect (i.e., in which nearly all the patients in both shared care and usual care recovered) may have occurred.

We wanted to know whether effectiveness varied according to assigned study quality ratings. Of the 24 studies that were rated of strong quality, 16 (67%) found that shared care was more effective than usual care (11 of 16 replacement groups and 5 of 8 C-L groups). Of the 16 studies that were of good or weak quality, 11 (69%) found that shared care was more effective than usual care (7 of 10 replacement studies, 2 of 3 C-L studies, and 2 of 3 education-liaison studies). In other words, effectiveness results do not appear to vary by study quality.

Are SMHC studies with certain characteristics more likely to be effective?

We looked at effectiveness by certain study characteristics, including the patient selection method used (how patients were recruited and selected for the study), the type of mental health problem(s) with which patient participants presented, type of mental health treatment provided, type of MHP involved in the intervention, and whether there was a patient education component:

- **Patient selection:** Some studies used diagnostic or screening tools to determine patients' eligibility for participation, while others relied exclusively on FPs' clinical judgment. Of the ten studies in which the FP selected participants, shared care significantly improved outcomes for only three of them (30%). Of the 30 studies in which diagnostic or screening tools were used, shared care significantly improved outcomes for 24 of them (80%).
- **Type of mental health problem:**
 - Of 27 depression studies, 21 (78%) of them found shared care produced significantly better outcomes than usual care. When we looked at depression studies more closely by type of depression, shared care was more effective than usual care in 2 of 4 minor depression studies, 5 of 5 major depression studies, 0 of 1 dysthymia study, 2 of 2 mixed depression and anxiety studies, 4

- of 4 specialized studies (e.g., high utilizers, persistent depression), and 8 of 13 "unspecified depression" studies.
- There was one study each on panic disorder, anxiety, somatoform disorder, and psychoses, and they all found shared care to be superior to usual care in effectiveness.
- Of the nine studies that included patients with a broader range of mental health problems, such as non-psychoses, shared care was more effective than usual care in only two of them (22%).
- **Patient education:** Of the 14 shared care interventions that routinely included patient education, 13 (93%) were significantly more effective than usual care. Of the 26 groups that did not include patient education, only 14 of them (54%) were significantly more effective than usual care.
- **For type of mental health treatment and type of MHP,** there was too much variability to detect any clear pattern.

Were patients more satisfied with SMHC than usual FP care?

Of 15 groups that measured patient satisfaction, 12 (80%) found that patients were significantly more satisfied with shared care than with usual care.

How cost-effective is SMHC?

Because none of the three education-liaison studies conducted economic evaluations, our summary is limited to replacement and C-L models. The majority of the economic evaluation studies focused on patients with depression (major depression, minor depression, dysthymia, or unspecified depression), although a few focused more broadly on non-psychoses. We classified the economic evaluation studies as either *cost minimization* studies (i.e., studies in which shared care was no more effective than usual care) or *cost effectiveness* studies (i.e., studies in which shared care was significantly more effective than usual care). Given there was considerable variability across studies particularly in terms of the breadth of the cost data collected, the length of time for the follow-up period, and differences in study populations, aggregating this data in a summary fashion proved challenging. As well, the presence of small sample sizes in many of these groups precluded any assessment of statistical significance. The average sample size was 113 per treatment group, and ranged from 30 to 466.

The following presents our general impressions from the literature:

- In general, shared mental health care appears to be both more effective and more costly than usual care.
- **Replacement:** Curiously, most of the economic evaluations for the replacement model were cost minimization studies, despite the fact that the majority of replacement studies found shared care to be significantly more effective than usual care. Some of the replacement studies measured costs at more than one follow-up period, resulting in

14 comparisons of direct costs (e.g., costs of FP and MHP visits, hospitalizations, medications) and 4 of direct costs plus indirect costs (e.g., lost productivity costs) for the cost-minimization analyses, and 6 direct and 7 total (direct plus indirect) cost comparisons for the cost-effectiveness studies. These evaluations were based on a wide range of follow-up periods, but we did not detect any systematic differences in cost-effectiveness by length of follow-up period.

- For the cost minimization analyses, 9 of 14 direct cost comparisons (64%) and 2 of 4 total cost comparisons (50%) found shared care cost more than usual care.
 - For the cost-effectiveness analyses, we found that shared care cost more than usual care for 4 of 6 direct cost comparisons (67%) and 6 of 7 total cost comparisons (86%).
- **C-L:** Five of the seven economic evaluations for the C-L model were cost effectiveness studies. The two exceptions were analyses of minor depression, in which shared care was found to be no more effective than usual care and more costly, as the authors predicted. All five cost-effectiveness analyses—four with a 12-month follow-up, one with a six-month follow-up—demonstrated improved patient outcomes and greater costs. For four of the five groups, only direct (i.e., health system) costs were included. As well, one research team was responsible for this entire literature.

PHASE 2: IDENTIFICATION OF CURRENT PRACTICES IN PRIMARY MENTAL HEALTH CARE

Method

We conducted a mail survey of all family physicians (FPs) in Saskatchewan to determine, from FPs' perspectives, how common mental health problems are in Saskatchewan's primary care, the types and frequency of interaction that FPs have with mental health professionals, and strengths and areas for improvement in primary mental health care. We based some of the survey questions on the principles and communication strategies described in the 1997 position paper on shared mental health care in Canada, written jointly by the Canadian Psychiatric Association and College of Family Physicians of Canada. All questions were closed-ended except for two open-ended questions on strengths and areas for improvement for mental health care in the primary care setting: "What existing elements/characteristics in your primary mental health service delivery do you think are contributing to good patient care?" ("strengths" question) and "What do you think could lead to improvements in the mental health care you are able to provide to your patients?" ("areas for improvement" question). Seven family physicians and two psychiatrists pilot tested and provided comments on a draft version of the survey instrument.

With the assistance of the Saskatchewan Medical Association (SMA), we conducted three mailings of our survey to 816 physicians between May and September 2002. To ensure physician confidentiality and anonymity, the SMA coordinated the survey mailing process. The survey package mailed to physicians included a cover letter, the four-page survey questionnaire (with an arbitrarily assigned survey identification number in the top right

corner, randomly generated by the SMA), a pre-stamped response envelope addressed to the SMA, a "request for study results" address form, and a study overview that described the study, how respondents' anonymity was ensured, the informed consent process, and possible risks and benefits of participating.² The SMA collected and tracked completed surveys and refusals to ensure that physicians responding to earlier mailings did not receive the survey again, and to determine response rate.

We entered, cleaned, and analyzed the quantitative data from all completed surveys using SPSS. For each of the two open-ended survey questions, two researchers read through all the responses and developed a draft coding framework. After applying the framework to a sample of the responses, we revised the framework until both coders felt comfortable that it accurately and adequately captured responses. A research assistant coded all of the responses, and a second researcher coded 20 per cent of the responses to each question. The interrater agreement was 84 per cent for the "strengths" question, and 80 per cent for the "areas for improvement" question.

Findings

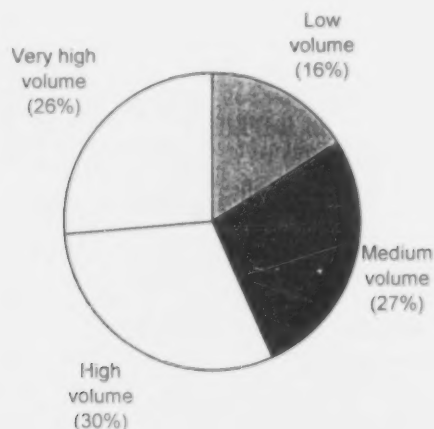
Of the 816 physicians who received our survey, 31 of them were determined to be ineligible (e.g., because they were emergency physicians, were no longer practicing, etc.), and 375 completed the survey, yielding a response rate of 48 per cent (375/785). There were no significant differences between respondents and nonrespondents in gender or number of practice years. For physician age, there was no significant difference between respondents and nonrespondents in those under 40 years of age and those 40 or older. However, when we analyzed age by smaller categories, we found that the response rate among physicians aged 60 or older (36%) was significantly lower than for those under 40 (45%), 40-49 (48%), or 50-59 years of age (52%). For community size, we found that the response rate for physicians from small rural communities (57%) was significantly higher than that for physicians from urban (42%) or large rural areas (42%).

How common are mental health problems in Saskatchewan's primary care setting?

As shown in Figure 1, we found that 16 per cent of respondents reported seeing 5 or fewer patients with mental health problems per week (low volume), 27 per cent reported seeing 6-10 per week (medium), 30 per cent reported seeing 11-20 per week (high), and 26 per cent reported seeing more than 20 patients with mental health problems per week (very high). (Due to rounding, summed percentages do not equal 100%.) We also found a statistically significant difference by community size in percentage of FPs seeing more than 10 patients with mental health problems per week: 43 per cent for FPs in small rural communities (population of less than 10,000), 52 per cent for those in large rural communities (population of 10,000-50,000), and 68 per cent for those in Saskatoon or Regina.

² We originally intended—and obtained permission from physician respondents—to link physician survey responses' to patient data on hospitalizations, physician visits, depression scores, health status, and other measures from Saskatchewan Health administrative databases and Statistics Canada's Canadian Community Health Survey. Due to delays in the approval process for data access, sample size limitations, and other factors, we decided not to link the data.

Figure 1. Proportion of FP respondents seeing low to very high volumes of patients with mental health problems



How physically accessible are mental health professionals to family physicians?

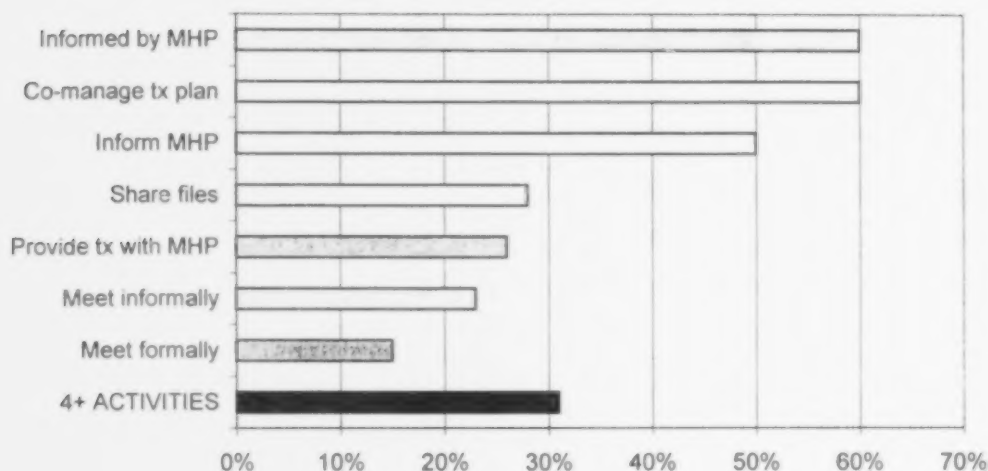
The survey asked family physicians about the presence of onsite, visiting, or nearby mental health professionals (psychiatrists, clinical psychologists, community mental health nurses, addictions counsellors, social workers, or "other mental health professionals"). Fifteen per cent of FPs, most of whom were from Saskatoon or Regina, reported having an onsite MHP in their practice setting; 18 per cent, most of whom were from small rural communities, reported having an MHP who visited their practice setting at least once a month; and 47 per cent reported having an MHP within a five-minute walk from their office.

How much and what kinds of interaction do family physicians have with mental health professionals?

The survey asked family physicians about their interactions with mental health professionals. First, we asked them how often they interacted with MHPs by written correspondence, by phone, and in person. As expected, written correspondence was the most common mode of interaction, with 85 per cent of respondents reporting that they communicate in this way at least once a month with MHPs. The percentage of respondents reporting written correspondence with MHPs did not vary significantly by community size. Seventy-five per cent reported interacting with MHPs by phone at least once a month, and these percentages did vary significantly by community size (82% in small rural communities, 91% in large rural, and 62% in urban). Fifty-three per cent reported monthly or more frequent face-to-face interaction with MHPs, and this also varied significantly by community size (53% in small rural, 65% in large rural, and 47% in urban).

We also asked family physicians to report the frequency of specific types of mental health related activities, most of which required interactions with MHPs. We report here on the seven activities that we consider core SMHC activities. The percentages in Figure 2 reflect the proportion of family physicians that reported engaging in these mental health (MH) activities once or more per month. The most common interactions included being informed

Figure 2. Percentage of FPs who engage in specific MH activities



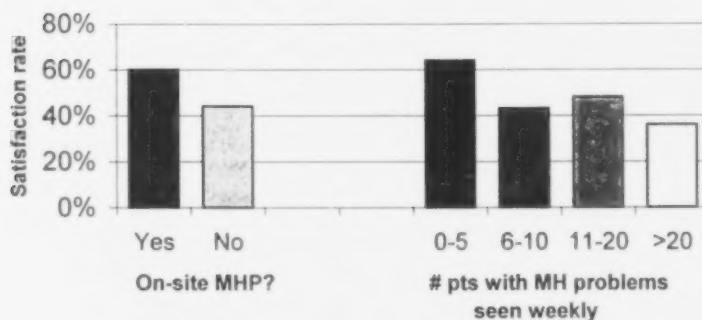
by MHPs of patients' ongoing treatment and co-managing mental health patients' treatment plans (in collaboration with MHPs), with 60 per cent of FPs reporting they engaged in these activities. Half of FPs reported they informed MHPs of patients' ongoing treatment, 28 per cent shared files of common patients with MHPs, and 26 per cent provided treatment or assessment to patients with an MHP present. The least common interactions were meeting formally (15%) or informally with MHPs (23%) to discuss common patients. Thirty-one per cent of family physicians engaged in four or more of these activities, and this varied significantly by FPs' community size: 25 per cent for urban, 31 per cent for large rural, and 41 per cent for small rural FPs.

How satisfied are family physicians with their mental health care delivery?

Less than half—46 per cent—of family physicians reported being satisfied or very satisfied with the mental health care they are able to deliver to patients. As shown in Figure 3, physician satisfaction was significantly higher among those with an onsite MHP (60%) than those without an onsite MHP (44%). Physician satisfaction also varied significantly by the number of patients with mental health problems seen weekly (see Figure 3). In general, the more patients with mental health problems seen weekly, the less satisfied physicians were with the mental health care they provided. Physician satisfaction did not differ significantly by community size, presence of visiting or nearby MHPs, interaction by phone, by written

correspondence, or in person, or by number of core SMHC activities completed monthly or more often.

Figure 3. FP satisfaction rate by presence of onsite MHP and by MH volume



How interested are family physicians in mental health problems?

Eighty-three per cent of family physicians reported they were interested or very interested in identifying or treating mental health problems. Physician interest in mental health varied significantly by community size (85% in small rural, 73% in large rural, and 88% in urban), but not by any other key variables.

What strengths and areas for improvement do family physicians see in the mental health care they provide to patients?

For the "strengths" question, most coded responses fell under four broad categories (examples of specific codes listed in parentheses):

1. Characteristics of the physician's approach to mental health care (e.g., personal interest in mental health issues, basing mental health treatment on evidence)
2. Characteristics of the physician's approach to patient care (e.g., taking the time needed with patients, following patients' care past the visit)
3. Characteristics of the team (e.g., having access to MHPs, respecting skills/value/input of MHPs)
4. Characteristics of the practice (e.g., having an onsite MHP, alternate payment scheme)

The characteristics of primary mental health care that physicians most commonly identified as strengths (i.e., the most common codes) are listed in Table 1. Having access to psychiatrists, community mental health nurses, and other MHPs was the most common response, and several physicians noted the importance of *timely* access in particular. Another commonly identified strength was having a focus on detection, awareness, early intervention, or prevention of mental health problems, and the importance of screening for or monitoring

mental health symptoms. Counselling, taking the time needed with patients, and having an onsite or visiting MHP were also common responses.

Table 1. Most common strengths identified by FPs

- Access to MHPs
- Focus on detection/awareness/prevention/screening
- Counselling, listening to patients
- Taking the time needed with patients
- Staying current in MH training/Basing practice on evidence
- Respecting the skills/value/input of MHPs
- Having an onsite or visiting MHP

For the "areas for improvement" question, most coded responses fell under four broad categories (examples of specific codes listed in parentheses):

1. Access (e.g., access to specific MHPs, timely access, access for specific populations/needs)
2. Family physician care (e.g., educational opportunities on mental health care, remuneration/payment schemes for FPs)
3. MHP care (e.g., recruitment/retention of MHPs, remuneration/payment schemes for MHPs)
4. Continuity/team-based approach (e.g., follow-up/consultation notes, confidentiality/informed consent issues)

The most common areas for improvement in primary mental health care that physicians identified are listed in Table 2. Most suggestions for improvement fell under the broad category of access. Improving access to specific MHPs, especially psychiatrists, was by far the most common response overall. Another common response, closely related to MHP

Table 2. Most common areas for improvement identified by FPs

- Access to specific MHPs
- MH resources
- Timely access to specialty MH care
- Access for specific populations/needs
- Nearby access (e.g., onsite/visiting MHP)
- FP education/information on MH problems and resources
- Communication with MHPs (e.g., consultation notes)

access, was the need to increase mental health resources, such as human resources, mental health beds, and the mental health budget in general. Many physicians also expressed dissatisfaction with access to specialty mental health care for specific populations or needs,

such as child and adolescent psychiatry, emergency cases, or new referrals. Timely MHP access, nearby MHP access, and educational opportunities for family physicians in mental health care were also commonly identified areas for improvement.

PHASE 3: CHALLENGES AND SOLUTIONS TO ACHIEVING BEST PRACTICES IN PRIMARY MENTAL HEALTH CARE

Methods

Our starting point for this phase was a literature review on challenges and solutions to shared mental health care. The major challenges identified in the literature review included:

- Inappropriate or inadequate remuneration and funding for shared mental health care activities
- Lack of role definition, responsibility, and flexibility among FPs and MHPs
- Time constraints of FPs and MHPs
- Inadequate access to MHPs
- Diverse community needs depending on community size, demographics, FP and MHP distribution, treatment philosophies, and other factors
- Logistical issues (e.g., physical space if co-location is involved; administrative support; sharing of files)

Building on the findings from our literature review, we also conducted qualitative research, using the story dialogue method,⁷⁶ to get a better sense of challenges and solutions specific to Saskatchewan. The story dialogue method offers a structured way to explore stories around a particular theme. By collectively reflecting on and analyzing personal experiences, the story dialogue method enables participants to develop a deeper understanding of the world, its effects upon them, and potential for improvement.

We recruited participants by inviting nominations from our working group members and various other mental health stakeholders. In recruiting and selecting our participants, we deliberately attempted to get representation from all stakeholder groups and from both rural and urban areas. Our final group of 28 participants consisted of 6 managers, 2 psychiatrists, 18 other mental health professionals, and 2 consumer advocates; 14 were from rural areas, 10 from urban, and 4 from the north. Unfortunately, we were unsuccessful in recruiting any family physicians.

The story dialogue conducted for the shared mental health project was a five-hour workshop held in November 2002. The 28 participants were broken into three smaller groups, with a trained facilitator in each group. Each small group had one story teller who had been asked to prepare his or her story in advance and share it with the group. The stories for the workshop came from each teller's own experiences, and contained three key elements: 1) a detailed description of what happened, 2) one or more explanations for what happened, and 3) the teller's reflections on what happened and why. The stories were told from a single point of view. The theme was described as integrated mental health care in the primary care setting.

The group facilitators explained the story dialogue process to their groups, and in particular noted that the dialogue was not concerned with reaching consensus on the accuracy of the story, but with reaching consensus on useful, general lessons about practice. The story tellers then told their stories to their respective groups. A reflection circle followed in which all listeners were asked to reflect on how the story was also their story and how the issues were similar to or different from their experiences. Following the reflection circle, all story listeners had an opportunity to ask questions of the story teller, and of the other group members. This structured dialogue used four types of questions: description, explanation, synthesis, and action. The structured dialogue, which was facilitated, allowed the group to synthesize the key lessons from the group members' collective experiences. Based on the discussions, the group members used index cards ("insight cards") to capture key lessons or insights that represented for them something that was important in practice and worth sharing with other people beyond the small group.

The story tellers then switched groups so that each group had two stories and two rounds of reflection, structured dialogue, and insight cards. Following the rounds of the story dialogue method, the small groups moved to a space on the wall where they put their own insight cards up onto the wall. They then grouped together similar ideas and generated categories from their insights. Each small group verbally described the linkages across their insights and categories to the other small groups. This description and the discussion that followed, where the large group connected all of the descriptions together and identified linkages, were videotaped and transcribed for further analysis.

The data that were analyzed included: all insight cards as they were placed by participants on the walls; the transcription of the presentations and discussion; and, the facilitators' notes about additions to or clarifications of the transcripts.

The facilitators individually generated codes from the data and then, as a group, came to agreement on a framework for broad coding. A research assistant coded the entire data set, consulting with the other researchers for validation, sub-coded, and identified linkages across the codes and sub-codes. The group of researchers then came together again to reach consensus on the analysis. We sent workshop participants the summary of themes for their review and validation.

Findings from the Story Dialogue Workshop

The main themes that emerged from the analysis of the story dialogue data are related to:

- Teams
- Communication
- Education and professional development
- Time and flexibility of time
- Current structure of the system
- Perceptions of mental health
- Funding
- Support for mental health professionals

The following description of each of the main themes is written from the perspective of participants' collective experiences. Within each theme, participants identified several challenges and solutions, as noted.

Story dialogue participants said this about TEAMS:

Working as a team is best for patient care, but the whole concept of team is a *challenge* to fit the needs of the client or community. A *solution* is to change and broaden the definition(s) of the team through an evolving process. Teams can be more inclusive by having informal links where appropriate.

A *challenge* is defining who is part of the team. All the disciplines and people involved with the client (e.g., MHPs, FPs, nurses, etc.) should form the team. A *solution* is to extend our definition beyond traditional health and mental health services (e.g., social services, education, etc.). We should collaborate with allied agencies through community interagency committees, but also explore existence of and our involvement in care teams perhaps led by other sectors (e.g., wrap-around teams). Other *solutions* are to include management as part of the team in order to identify and act on "windows of opportunity," and to share their knowledge about access to resources. The bureaucracy is there to support the team and the team is there to support the client's needs.

A community generates needs and one *challenge* to best practices in integrated mental health services is operating from what we perceive as a community's needs. A *solution* is for the team, including the client and community, to identify the primary needs of the community and keep those needs at the centre of all initiatives. At the same time, a community generates resources to help resolve or improve some of these issues and so another *solution* is to maximize our use of these community resources, and to include clients and community members as part of the team. Community members are "specialists" in their communities in the same way that mental health professionals are "specialists" in mental health.

A *challenge* is that the one-on-one or clinical approach is not always the most effective means of delivering mental health services. A *solution* is to include support groups or wrap-around models, which are more empowering for the client, as part of the array of tools available.

A *challenge* is when team members are resistant to involving other people or disciplines in the client's or community's care. They may feel like they are the only person or discipline who can deal with the client's or community's particular challenge, and may sometimes be expressed as power or control over care decisions. A *solution* is for individual team members and teams as a whole to have the courage to recognize their own limitations and draw on other resources when appropriate. Another *solution* is that team members get to know each other formally and informally—their backgrounds, where they are coming from—and build a sense of trust with the other members of the team. Integrated case management, or wrap-around, has the potential to increase collaboration (*solution*); however, flexible structures are essential to support this (*challenge*).

A *challenge* is that physicians do not seem to have a team orientation to client care and yet they are seen as the main gatekeeper of primary care. Payment models may be contributing to

a more individualized orientation. A *solution* is to create a broader range of entry points with specialized knowledge and experience in mental health, such as mental health specialists conducting screenings in the primary care setting.

One general *solution* to challenges with teamwork overall is co-locating health services potentially encouraging teamwork. Another general *solution* is increasing opportunities for interaction, communication, education, and professional development to enhance team members' levels of understanding of each profession's roles, responsibilities, expectations, and approaches to mental health services.

Story dialogue participants said this about COMMUNICATION:

Communication is a vital element in sustaining teamwork. A *challenge* is that current structures for exchanging information across "team" members do not support collaboration. A *solution* is to integrate structures to facilitate the sharing of concerns and exchange of information between members of the multi-disciplinary team (e.g., monthly meetings, case conferences, shared charting, updates of relevant chart information). Team members should also have opportunities to access information and communicate with others directly or via the internet or telephone about tools available and best practices or successes. Another *solution* is that team members communicate with one another using a common language.

Story dialogue participants said this about EDUCATION AND PROFESSIONAL DEVELOPMENT:

A *challenge* is that disciplines involved on the "team" do not have the appropriate training to assess and care for mental health issues, particularly family physicians. A *solution* is to have opportunities for education and professional development for all disciplines involved on the team, and to have good assessment tools and agreement on assessment tools. Education and time are required in order to train the primary health care team about the appropriate use of these tools.

A *challenge* (also identified in "team" section above) is that team members operate from what they perceive to be a community's needs. A *solution* is to first understand and be involved in the community in order to identify community needs and priorities and then address or broaden education around those issues.

A *solution* to both of the challenges above is to have cross-cultural training and gender analysis incorporated into the education and professional development provided in order to be able to recognize and address inequities in service.

Story dialogue participants said this about TIME/FLEXIBILITY:

Time is a luxury that many mental health providers currently do not have. A *challenge* is that time is required in order to get to know the client and deliver his/her care, coordinate care, access specialists in a timely manner, and collaborate with or consult other team members. A *solution* is to have time allotted for professional development and training so that health care providers can learn about and identify the appropriate tools needed. Another *solution* is

having flexibility in your workday that allows the freedom for working in the field and for considering consulting with the patient or other team members first rather than referring out.

Story dialogue participants had CONCERNS ABOUT THE WAY IN WHICH THE CURRENT SYSTEM IS STRUCTURED:

Consistency in Access to Mental Health Services: A *challenge* is that there is sometimes a lack of direct access to mental health services. The model of an integrated health authority is a *solution* to ease transitions between community and acute services. Another *solution* is using technology to deliver mental health services, such as telepsychiatric consultations (videoconferencing to support clinical psychiatric care at a distance) and clients accessing self-management programs through the internet. Technology also increases access by allowing physicians and mental health care providers situated in rural communities to consult with specialty services via the internet about assessments, education, and other daily activities.

A *challenge* is to know who is accessing mental health services, who is not, or how timely is their access. A *solution* is to explore the sources of gaps in accessing mental health care. Another *solution* is to make time available and develop tools to reach these populations who are not accessing services.

There is a *challenge* with variations in care plans depending on how a community member accesses a service, or what service or discipline initiates client care. A *solution* is centralized intake (single point of entry for clients needing mental health services) to provide all disciplines with the opportunity to meet and negotiate who is going to take initial responsibility for the patient's care. Another *solution* is assigning a designated professional responsible for ensuring the patient's plan of care is being followed, particularly for complex cases.

Advocacy Role: There is a *challenge* with not having advocates to support flexible and effective structures, to clarify approaches (such as primary health care), or to place issues at a broad system level. Mental health is not always acknowledged to be a part of primary care. A *solution* is for provincial advisors to be better advocates in these areas. The Health Quality Council was seen as having a system-level perspective.

Crisis Orientation: It is a *challenge* to maintain a preventative approach and to use preventative tools when the system is designed to encourage a crisis orientation.

Jurisdictional Issues for Mental Health Service Delivery: It is a *challenge* to define how to work together across geographic (rural/urban) and governance (FN/federal/provincial/regional) boundaries. Integrated health authorities and integrated committees are a *solution* to help to address this. Payment models can also be a *challenge* for collaboration, i.e., federal/provincial responsibilities.

Confidentiality: Informed consent and sharing patient information present *challenges* to integration in the primary care setting. A *solution* is to have clients sign a general consent form that allows exchange of information between providers.

Story dialogue participants said this about how others PERCEIVE MENTAL HEALTH:

It is a *challenge* when social issues (such as poverty and violence) are defined inappropriately as mental health issues. A *challenge* is when physical symptoms associated with mental health concerns may not be recognized as such in physicians' offices, such as somatization of stress. What presents may not be the issue that actually needs to be addressed and we continue to treat the symptoms and not the root cause.

A *challenge* is the stigma associated with mental illness. It impacts on clients when they resist accessing or receiving services, and it impacts on providers when they are not sure how to relate to clients outside of their offices, e.g., when they are known as the "mental health counsellor." A *solution* is to replace "mental health" in titles with something more widely accepted by the community (e.g., "community counsellor" rather than "mental health counsellor"). The decentralization of services has also assisted with breaking down the stigmatization associated with mental health.

Story dialogue participants said this about FUNDING:

Mental health professionals feel undervalued as a result of the lack of funding they receive in comparison to other areas of health care (*challenge*). A *solution* is to provide mental health services with a share of health care funding proportional to the prevalence of mental health issues in society.

Story dialogue participants said this about SUPPORTING MENTAL HEALTH PROFESSIONALS:

A *challenge* is knowing how to take care of yourself in order to care for your clients. A *solution* is to understand and accept what your limitations are as one individual. Another *solution* is to start on one area or strategy even though there are others that are equally important.

A *challenge* is defining reasonable caseloads for mental health providers in order to allow the time for collaboration.

DISCUSSION

Through this project, we have learned or reinforced the findings of others that:

- A majority of shared mental health care models, particularly those that include patient education, use screening or diagnostic tools to select patients, and that focus on one specific mental health problem, produce significantly better outcomes and higher patient satisfaction rates than usual FP care.
- Mental health problems are common in primary care.

- Overall, family physicians' satisfaction with the mental health care they are able to deliver is low, yet their interest in the area is high.
- Family physicians who treat a lower volume of patients with mental health problems or who have an onsite MHP are more satisfied with the mental health care they are able to provide.
- Access to MHPs is both the most commonly cited strength and most commonly cited area for improvement among physicians.
- Teamwork, communication, education, and system structure issues present both key challenges and key opportunities for improvement in primary mental health care.

Our findings raise interesting questions and have important implications for quality improvement and strategic planning in mental health services.

How can we best address challenges and build on strengths in primary mental health care?

We learned about challenges in primary mental health care through the open-ended questions from our physician survey, our "challenges and solutions" literature review, and our focused workshop using the story dialogue method. Although there were some differences in the challenges, areas for improvement, and solutions identified in each, there were many important similarities as well. Some of the issues we heard repeatedly were access to MHPs; having or creating the time needed to treat mental health problems; lack of communication and teamwork, in part due to issues around social stigma, confidentiality and informed consent; and limited knowledge about mental health issues, treatments, and the skill sets that various providers offer. In addition to the blanket suggestion to increase health system resources devoted to mental health care, we learned about several other specific strategies to address these issues, the most promising of which include: better training and continuing education opportunities for FPs and MHPs in primary mental health care; having structures in place to encourage collaboration and sharing of information, such as monthly team meetings or dedicated time for phone liaison; remuneration schemes that reward and appropriately compensate for teamwork and sharing of information; and onsite MHPs.

We also learned about several strengths in primary mental health care in Saskatchewan. Interesting, access to MHPs was the most common area for improvement identified by family physicians responding to our survey, but it was also the most commonly cited strength. We conclude from these findings that access to MHPs is a crucial issue for FPs. Those physicians who felt they had good access to MHPs for their patients recognized this as a strength; those who felt they did not, cited this as an area for improvement. It might prove useful to do further study of FPs who cited good access to MHPs versus those who did not: Were the former more likely to have an onsite MHP? have better working relationships with MHPs? Did the latter have a lower ratio of MHPs in their respective regions or communities? have less knowledge about the mental health services available in their respective areas? Another characteristic that was noted as both a strength, by some participants, and an area for improvement, by others, was teamwork or relationships among providers.

Participants in both our physician survey and our focused workshop noted individual characteristics, such as a focus on detection and prevention and a deep commitment to patient/client care, as strengths. Perhaps these individual strengths can be even more effective in an environment of mutual respect and a system that supports flexibility, educational opportunities, and structures or policies to facilitate communication—all identified by our participants as strategies to improve primary mental health care.

Having onsite MHPs was identified as a strength in several of our findings. FPs identified onsite or visiting MHPs as a strength in their open-ended survey responses, and participants in our focused workshop also mentioned onsite MHPs as one promising model to improve primary mental health care. Also, the satisfaction findings from our physician survey revealed that FPs with onsite MHPs were significantly more satisfied with the mental health care they provided than those without an onsite MHP. Although shared care, especially the consultation-liaison model, consists of more than the mere presence of an onsite MHP, it is the structural requirement of replacement and consultation-liaison models of shared care.

We also consider the high level of interest in mental health issues expressed by family physician respondents to be a strength of primary mental health care in Saskatchewan. Over 80 per cent of our survey respondents reported they were interested or very interested in identifying or treating mental health problems. In interpreting this finding, we must keep in mind that while we had a good response rate to our survey, the respondents were not representative of all family physicians in Saskatchewan, at least in terms of physician age and community size. Although we have no data to test this, it is possible that those family physicians with more interest in mental health issues were more likely to respond to the survey than those with less interest. Nonetheless, even if an interest in mental health issues is not shared by the majority of nonrespondents, there were over 300 family physicians responding to our survey who did report such an interest. This suggests that Saskatchewan has a considerable contingent of family physicians who are motivated to improve primary mental health care.

Are some SMHC models more effective than others?

Whether we looked at all the SMHC studies together, or stratified by model (education-liaison, replacement, and C-L), about two-thirds of the studies found that shared care was significantly more effective than usual care. There was incredible variability in the SMHC studies included in our systematic literature review in terms of sample size, patient eligibility criteria, type and intensity of mental health treatment, exposure (i.e., to what extent the planned treatments were actually received), type of MHP involved in the intervention, length of follow-up period, outcome measures, and other key characteristics. Such variability makes it difficult to determine which characteristics are most important in improving patient outcomes. This evidence gap exists for many "best-practice" models, and has been noted for best practices in mental health services in particular.⁷⁷

What we can do, based on available evidence, is assess the relative effectiveness of shared care models that include specific components and those that do not, to see if we notice any patterns. Our comparison revealed that the effectiveness rate of models that include patient

education, use screening or diagnostic tools to determine patient eligibility, and are focused on one specific type of mental health problem (e.g., depression) were higher than those that did not have these components. Similarly, other systematic reviews of shared mental health care have suggested that effectiveness may be better in studies using criterion-based diagnostic assessment¹⁵ and that focus on a specific mental health population.¹⁷

However, just because we examined these characteristics separately in our analysis does not mean that they are independent of each other. For example, most of the studies that focused on one particular mental health problem used screening or diagnostic tools to determine patient eligibility. It is difficult to say whether the use of tools, the focus on one mental health problem, or a correlate of one or both characteristics is the best predictor of the effectiveness of shared care. Did the patients in studies that used screening tools have less severe symptomatology? Were studies that focused on one particular mental health problem more likely to use structured or manualized treatments? To establish a causal relationship between these components and effectiveness, further research would need to explore how the presence or absence of specific components in SC models affects patient outcomes. For now, we can say that components such as patient education, use of screening or diagnostic tools, and a focus on a specific mental health problem each appear to be associated with higher rates of effectiveness and should be considered when developing and implementing a shared care model. It is also worth noting that the consultation-liaison program developed by Wayne Katon and others from a Seattle-based health maintenance organization has had particular success. Seven of their studies, all of which included patient education and used screening tools, and all but one of which focused specifically on depression, were included in our systematic literature review. Six of the seven found their shared care intervention to be significantly more effective than usual FP care.

Although the majority of studies focused on replacement and education-liaison, education-liaison models show promise as well. Unfortunately, none of the three education-liaison studies conducted cost analyses. However, two of the three studies found shared care to be significantly more effective than usual care, and it is likely that less intensive interventions like education-liaison will be less expensive than replacement or consultation-liaison.

It is difficult to say whether SMHC is more effective for some types of mental health problems than others. There is some suggestion from this project, particularly the research by Katon et al., that SMHC is more effective and cost effective for major depression than minor depression, and perhaps more effective for moderate forms of major depression than severe forms. It may be that SMHC is least effective for extreme forms and most effective for moderate forms of major depression, as suggested by Walker.⁷⁸ Unfortunately, the scope of mental health problems in SMHC studies is quite narrow, focusing primarily on depression, anxiety, and other non-psychoses, leaving the question of SMHC's effectiveness with psychoses or severe and enduring mental disorders yet to be answered.

We did not find that length of follow-up affected the proportion of studies for which shared care was more effective. This is contrary to Bower, Rowland, and Hardy's¹⁶ meta-analysis of counselling in primary care, in which they found that counselling produced significantly better clinical outcomes in the short term (1-6 months), but not in the long term (longer than 6

months). However, as noted by the authors themselves, the number of long-term studies included in their meta-analysis was small, and psychological therapies for more minor mental health problems may be less likely to produce benefits superior to usual care over the long term.

Is SMHC cost-effective?

As noted earlier, there are several factors that make it difficult to answer this question, including the tremendous variability in the SMHC economic evaluations we reviewed, and the fact that many were likely underpowered. Bower et al.¹⁶ conducted an economic meta-analysis of counselling in primary care to address this power issue. Three studies were pooled for their cost-effectiveness analysis. Before pooling, counselling was more expensive in both the short term and the long term for all three studies; however, these differences were statistically significant for only two of the studies in the short term, and none of them in the long term. The meta-analysis results showed that counselling was significantly more expensive in both the short term and the long term. Because of this limitation, we chose to report only the direction of the differences, and not their statistical significance. Our summary of the SMHC economic evaluations suggests that overall, SMHC is both more effective and more costly than usual care. The question then becomes, how much can we justify paying for the increased effectiveness of SMHC (or how much better does SMHC have to be to justify its additional costs)?

Of all the cost-effectiveness analyses we reviewed, seven (four replacement and three C-L) calculated costs per quality-adjusted life year (QALY) gained. Given the wide variability in types of costs included, outcome measure used, and QALY calculation method, estimated costs were also highly variable, ranging from US\$9,478 to \$49,500 per QALY gained, and averaging about US\$25,000 per QALY. Although several authors note that this is consistent with the approximate costs per QALY of other acceptable health care interventions, such as pharmacotherapy for hypercholesterolemia among patients at moderate risk of heart disease,⁶⁶ there is considerable debate in the literature about the appropriateness of such comparisons.⁷⁹ More evidence and more consideration by mental health managers and health system policy makers is needed to assess how cost-effective SMHC is (or certain models or components are) relative to other widely used mental health interventions in which mental health budgets are currently being invested.

How do you know whether the SMHC models used elsewhere will work in Saskatchewan?

One of the limitations of this project was the lack of evaluation of Saskatchewan-based initiatives in primary mental health care. Our best advice for implementing a successful, effective SMHC program is to review the best evidence of what works and does not work; initiate discussions with others who have implemented similar programs to learn their experiences with successes, challenges, and lessons learned; be adaptable; and entice the involvement of influential, committed, visionary opinion leaders who can champion the process. Our project provides some of that evidence base; for more information on SMHC programs in Canada, please contact the Health Quality Council.

A VISION OF PRIMARY MENTAL HEALTH CARE

Our key findings suggest there are both strengths and areas for improvement in the quality of mental health services delivered in the primary care setting. Improving access to mental health professionals, satisfaction of patients and providers, and mental health outcomes will require innovative ways of delivering mental health care in the primary care setting. We encourage stakeholders to explore various evidence-based innovations to improve quality in mental health primary care. For this project, we chose to focus on one particular innovation, shared mental health care.

The results of our project suggest that shared mental health care is indeed an effective model for improving quality. Therefore, while we recognize that other innovative models of mental health primary care may also hold promise, our vision of mental health primary care in Saskatchewan focuses on strategies for promoting and implementing shared mental health care.

Recommendations of the HSURC Working Group

The recommendations that follow were developed by HSURC's study working group. The Board of the Health Quality Council (HQC) will consider them in terms of its mandate and priorities.

1. Saskatchewan health care agencies and providers promote awareness of shared mental health care, including benefits, potential challenges, and opportunities to adopt the approach in the province.

In particular, we recommend that:

HQC raise awareness of shared mental health care by sharing findings of this research project with Saskatchewan Health, health regions, health professional bodies, educational bodies, primary health sites, consumer advocacy groups, and any other relevant stakeholder groups through presentations and dissemination of written documents. We also recommend that **HQC** inform stakeholders of funding opportunities for pilot projects in shared mental health care or other innovative models of improving quality of mental health primary care.

Saskatchewan Health encourage and support health regions to incorporate mental health, mental health professionals, and SMHC elements in its primary health care initiatives.

Regional health authorities, professional bodies, educational bodies, and consumer advocacy groups promote SMHC and its benefits among its members or stakeholders.

Family physicians, mental health professionals, and mental health and primary health care managers initiate discussions to assess the feasibility of implementing SMHC in their communities or regions.

2. HQC provides or develops tools to support quality improvement initiatives in primary mental health care.

HQC would scan the literature and consult or partner with Saskatchewan stakeholders to determine what tools would be most relevant, but examples of tools could include:

- List and description of screening instruments for mental health problems that are inexpensive or free, quick, easy-to-use, and well validated;
- Standardized referral form for psychiatry and other mental health services; and,
- User-friendly guide, including relevant examples, to informed consent and confidentiality for patients with mental health problems.

3. Primary health sites, health centres, and family physician practices explore, implement, and evaluate approaches to shared mental health care that are based on evidence and local needs.

The evidence suggests several elements may improve the effectiveness of SMHC, but that should be flexible to and reflect the needs of the population or community. These elements may include, but are not limited to, the following:

- Screening or diagnostic tools to determine eligibility for the SMHC program;
- Mechanisms to increase access to team members, such as:
 - having an on-site mental health professional;
 - regularly scheduled team meetings, such as a monthly “Primary Health Forum” among family physicians, mental health professionals and other health professionals, via telehealth, teleconference, or in-person; or,
 - a dedicated block of time during which psychiatrists or other mental health professionals are available to family physicians by phone, email or fax to address “quick response” requests such as advice on medication or sharing of information.
- Mechanisms to promote communication and sharing of information, while respecting patient confidentiality;
- Appropriate fee structures for family physicians and mental health professionals for SMHC activities (such as those suggested above);
- Patient education; and,
- Focus or specialization on single mental health problem.

4. Professional and educational bodies provide health professionals with appropriate training opportunities in shared mental health care.

In particular, we recommend that:

Professional bodies offer continuing education sessions on SMHC for physicians, nurses, and mental health professionals; and,

Health science colleges provide formal and practical SMHC training for health science students, preferably in an interdisciplinary environment.

5. HQC evaluates the quality of primary mental health care in Saskatchewan.

A common observation in quality improvement circles is "you cannot manage what you do not measure." To improve quality of primary mental health care, we must first measure it. One of HQC's priority themes is primary health care, and plans are already underway to measure aspects of primary health care quality in Saskatchewan. The high volume of mental health problems in primary care, the economic burden of mental disorders on the health system, and the areas for improvement highlighted in this report all point to the need for HQC's primary health care initiatives to include a focus on the quality of mental health care. Process measures of quality could include rates of detection of mental health problems, access to mental health professionals, and family physicians' skill level or comfort with treating mental health problems. Outcome measures of quality could include patient symptom levels, patient satisfaction, and provider satisfaction. Evaluation of processes and outcomes of primary mental health care could also be built into the evaluation framework being developed for Saskatchewan Health's primary health care initiatives.

PROJECT WORKING GROUP AND HQC STAFF INVOLVED

The working group for this project included the following members: James Irvine (Chair), Roger Bitschy, Leslie Christianson, Greg Drummond, Dave Galloway, Moira Gautron, Nikki Gerrard, Roxanne Inch, Doug Jurgens, David Keegan, Joseph Michel, Shirley Skelton and Beth Vachon.

The HQC team for this project were researchers Heather MacDonald (who led the project), Lisa Clatney, and Tanya Dunn-Pierce.

Other staff involved in the project were: Greg Basky, communications director (who edited the report), Jennifer Dyck and Amanda Neudorf (library assistance), Lisa Fedorowich, research assistant (who coded qualitative data from the physician survey and workshop), Dianne Ferguson, knowledge transfer officer, Tara Finlay, research assistant (who conducted literature searches and appraisal), research assistant Noreen Grenkow and research analyst Nedeene Hudema (who assisted with survey analysis), Barb Nisbet, executive assistant (who proofread the final draft) and Erin Walling, researcher (who served as designated reader).

PROJECT RESOURCES

To obtain a copy of the appraisal tool for our systematic literature review, survey instrument, coding frameworks for the open-ended survey questions, "challenges and solutions" literature review, or any other project materials, please visit our web site: www.hqc.sk.ca or contact the Health Quality Council.

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